



## CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) ENROLLMENT FORM

INSTRUCTIONS: Please print.

### 1. Parent or Guardian Information.

|           |  |                |
|-----------|--|----------------|
| LAST NAME | FIRST                                      | MIDDLE INITIAL |
| ADDRESS   | CITY                                       | STATE          |
| ZIP CODE  | HOME/MESSAGE TELEPHONE (include area code) |                |

### 2. Children in Your Household. Write in the information for the children covered by CHIP.

| TB | Name<br>(Last, First, Middle Initial) | Date of Birth<br>(Month-Day-Year) | Sex<br>M/F | Social Security Number | Doctor Name and/or Clinic<br>(see <b>TIP</b> in section 3 below) |
|----|---------------------------------------|-----------------------------------|------------|------------------------|--|
|    |                                       |                                   |            |                        |  |
|    |                                       |                                   |            |                        |  |
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|    |                                       |                                   |            |                        |  |
|    |                                       |                                   |            |                        |  |
|    |                                       |                                   |            |                        |  |
|    |                                       |                                   |            |                        |  |

### 3. How Your Children Will Get Care. You need to choose how your children are going to get their medical care. Your choices depend on where you live.

*If your children are American Indian or Alaska Native, you also have some choices in section 4 on the back of this form.*

First:

- Go to the county list on page 1 of the **CHIP Choices** guide enclosed with this form.
- Find your county and choose how your children will get care. You cannot be in a health plan that is not in your county, and you cannot be in fee-for-service unless fee-for-service is a choice in your county.
- Once you decide, check one of the boxes below.

**TIP:** If you have a doctor or clinic you would like your children to stay with, call to find out if they are with a plan in your county. If they are not and you have fee-for-service as a choice, ask if they will take your medical ID card and bill DSHS. Fill in the doctor information in section 2 if you have a doctor or clinic who is in a plan in your county.

- |   |  |
|---|--|
| <input type="checkbox"/> Columbia United Providers (CUP)            | <input type="checkbox"/> Molina Health Care (MHC)  |
| <input type="checkbox"/> Community Health Plan of Washington (CHPW) | <input type="checkbox"/> Premera Blue Cross (PBC)  |
| <input type="checkbox"/> Group Health Cooperative (GHC)             | <input type="checkbox"/> Regence Blue Shield (RBS) |
|   | <input type="checkbox"/> Fee-for-Service           |

Please turn the page over → → →

#### 4. Are Your Children American Indian or Alaska Native?

If **yes**, you have 3 choices:

- You can either sign up below for a Primary Care Case Manager tribal clinic or health center that is run by a tribe, Indian Health Services, or an urban Indian organization, or
- You can sign up for a health plan in section 2 *on the front* depending on what is available in your county, or
- You can sign up for fee-for-service below. See pages 6 and 7 of your **CHIP Choices** guide for more information.

| COUNTY   | CLINIC NAME              | CHOICE                   |  | COUNTY                 | CLINIC NAME                  | CHOICE                   |
|----------|--------------------------|--------------------------|--|------------------------|------------------------------|--------------------------|
| Ferry    | Inchelium Health Center  | <input type="checkbox"/> |  | Clallam                | Quileute Health Center       | <input type="checkbox"/> |
| Okanogan | Colville Indian HC       | <input type="checkbox"/> |  | Grays Harbor           | Roger Saux Health Center     | <input type="checkbox"/> |
| Clallam  | Lower Elwah HC           | <input type="checkbox"/> |  | Pacific                | Shoalwater Bay Tribal Clinic | <input type="checkbox"/> |
| Whatcom  | Lummi Tribal HC          | <input type="checkbox"/> |  | Stevens                | DC Wynecoop Memorial Clinic  | <input type="checkbox"/> |
| Clallam  | Sophie Trettevick IHC    | <input type="checkbox"/> |  | Snohomish              | Tulalip Tribes Health Center | <input type="checkbox"/> |
| Whatcom  | Nooksack Comm Clinic     | <input type="checkbox"/> |  | King                   | Seattle Indian Health Board  | <input type="checkbox"/> |
| Kitsap   | Port Gamble S'Klallam HC | <input type="checkbox"/> |  | Yakima                 | Yakama Indian Health Center  | <input type="checkbox"/> |
| Pierce   | Takopid Health Center    | <input type="checkbox"/> |  | <b>Fee-for-service</b> |                              | <input type="checkbox"/> |

#### 5. Children With Special Health Care Needs.

Of the children listed in section 2, are there any with a special medical condition or developmental delay?

☐ Yes ☐ No If yes, please write in the child's (or children's) name and special health conditions.

\_\_\_\_\_

#### 6. Signature

SIGNATURE OF PARENT OR GUARDIAN

DATE

**Need help or have questions? Call the Medical Assistance Helpline at 1-800-562-3022.**

The TTY/TDD number is 1-800-848-5429 for people who have difficulties with hearing or speech.

*Discrimination is prohibited in all programs and activities: No one shall be excluded on the basis of race, color, national origin, sex, age, religion, creed, or disability.*

#### FOR DEPARTMENT USE ONLY

| ELIGIBILITY VERIFIED BY | ENROLLED BY | PROCESSING DATE | EFFECTIVE DATE |
|-------------------------|-------------|-----------------|----------------|
|                         |             |                 |                |